Arolygiaeth Gofal Iechyd Cymru
Healthcare Inspectorate Wales

Independent Mental Health Service Inspection Report (Unannounced)

Heatherwood Court

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Healthcare Inspectorate Wales (HIW) is the independent inspectorate and regulator of healthcare in Wales

Our purpose

To check that healthcare services are provided in a way which maximises the health and wellbeing of people

Our values

We place people at the heart of what we do. We are:

- Independent – we are impartial, deciding what work we do and where we do it
- Objective - we are reasoned, fair and evidence driven
- Decisive - we make clear judgements and take action to improve poor standards and highlight the good practice we find
- Inclusive - we value and encourage equality and diversity through our work
- Proportionate - we are agile and we carry out our work where it matters most

Our goal

To be a trusted voice which influences and drives improvement in healthcare

Our priorities

- We will focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- We will adapt our approach to ensure we are responsive to emerging risks to patient safety
- We will work collaboratively to drive system and service improvement within healthcare
- We will support and develop our workforce to enable them, and the organisation, to deliver our priorities

Contents

1. What we did

Full details on how we inspect the NHS and regulate independent healthcare providers in Wales can be found on our website.

Healthcare Inspectorate Wales (HIW) completed an unannounced independent mental health inspection at Heatherwood Court on 04, 05 and 06 December 2023.

The following hospital wards were reviewed during this inspection:

- Caernarfon – a locked rehabilitation unit with 11 single gender beds
- Cardigan – a low secure unit with 12 single gender beds
- Chepstow - a low secure unit with 12 single gender beds

At the time of the inspection the hospital was being managed by Iris Care Group.

Our team for the inspection comprised of two HIW Healthcare Inspectors, four clinical peer reviewers (one of whom was the nominated Mental Health Act reviewer) and one patient experience reviewer. The inspection was led by a HIW Senior Healthcare Inspector.

During the inspection we invited patients or their carers to complete a questionnaire to tell us about their experience of using the service. We also invited staff to complete a questionnaire to tell us their views on working for the service. A total of five questionnaires were completed by patients, and 25 were completed by staff. Feedback and some of the comments we received appear throughout the report. Where present, quotes in this publication may have been translated from their original language.

Note the inspection findings relate to the point in time that the inspection was undertaken.

This (full) report is designed for the setting, and describes all findings relating to the provision of high quality, safe and reliable care that is centred on individual patients.

A summary version of the report, which is designed for members of the public can be found on our website.

2. Summary of inspection

Quality of Patient Experience

Overall summary:
Staff interacted and engaged with patients appropriately and with dignity and respect. Patients had their own programme of care that reflected their individual needs and risks. Patients could engage and provide feedback about their care in a number of ways. Staff had undertaken equality, diversity and inclusion training to help recognise the importance of treating all patients fairly. Information was available to inform patients of their rights under the Mental Health Act. Patients had weekly access to a mental health advocate who provided information and support with any issues they may have regarding their care.

It was disappointing to find that the Social Hub, which included facilities such as a café and shop, was no longer in operation. We have asked the service to consider the feasibility of reinstating the Social Hub to provide an opportunity for patients to engage and relax with each other when appropriate.

This is what we recommend the service can improve:

- Patients must be provided with access to a dentist and other health services when required.

This is what the service did well:

- Patients were asked to complete outcome measures, and summary reports produced by staff contained recommendations to help improve patient experience and their wellbeing.

Delivery of Safe and Effective Care

Overall summary:
Staff were committed to providing safe and effective care. Suitable protocols were in place to help maintain the health and safety of patients, staff and visitors at the hospital. We found effective processes in place to help ensure that staff at the hospital safeguarded patients appropriately. The dietary needs of patients had been assessed on admission and specific dietary requirements had been identified and acted upon where necessary. The statutory documentation we saw verified that the patients were appropriately legally detained. The care and treatment plans we reviewed were generally being maintained in line with the Mental Health (Wales) Measure 2010.

The service had recently implemented an electronic Medication Administration Record system which had helped to reduce the number of medication errors occurring at the hospital. We saw that some patients were having their medication administered through a hatch in the clinic room door. We have asked the service to review the way medication is administered to fully protect the safety, privacy and confidentiality of patients.

Immediate assurances:
During the inspection we identified poor standards of cleanliness throughout all wards and the condition of the premises we observed was not reflective of a modern inpatient mental health service. Cleaning schedules we were provided with had numerous gaps which indicated that the required cleaning tasks were not always being undertaken. We were concerned that recent audit reports and environmental checklists undertaken by hospital staff had not identified the same issues.

We were also not assured that staff had received appropriate training in relation to resuscitation to ensure the welfare and safety of the patient in the event of an emergency.

Our concerns were dealt with through our non-compliance process. Details of the remedial action taken by the service in response are provided in Appendix B.

At the time of the inspection, Heatherwood Court was designated as a Service of Concern in line with HIW's Escalation and Enforcement process for independent healthcare services. Following inspection, it has remained a Service of Concern. HIW will continue to engage with senior management and the provider until it is satisfied with the actions taken to address required improvements.

This is what we recommend the service can improve:

- Medication fridges must be locked when not in use and the daily medication fridge temperature checklist must be completed to ensure that medication is being stored at the manufacturer's advised temperature
- Consent to treatment certificates must always state the correct type and dosage of medication that has been prescribed to patients
- The service must provide assurance to HIW that patients have received a capacity assessment
- Care and treatment plans must be developed, maintained and reviewed in line with the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

This is what the service did well:

- The environment of each ward was accessible for patients with mobility difficulties
- Kitchen staff attended the weekly community meetings to enable patients to raise any issues and to have input in the menus and suggest changes.

Quality of Management and Leadership

Overall summary:
Established and effective governance arrangements were in place to provide oversight of clinical and operational issues. Audit activities and monitoring systems helped to ensure the hospital focussed on improving its service. Staffing levels appeared appropriate to maintain patient safety within the wards at the time of our inspection.

The majority of staff said they would recommend the unit as a place to work and that they would be happy with the standard of care provided by the unit for themselves or their friends and family. However, some staff members provided feedback indicating that there was a poor working environment at the hospital. We have asked the service to engage with staff to further understand their views and provide assurance to HIW on what actions it will take to address the concerns raised.

This is what we recommend the service can improve:

- The service must continue to recruit more permanent staff to reduce the feeling among some staff that they do not have enough time to give patients the care they need
- Staff members must receive their annual performance development reviews with evidence provided to HIW on current compliance rates.

This is what the service did well:

- Recruitment was being undertaken in an open and fair process with appropriate employment checks being carried out prior to employment.

3. What we found

Quality of Patient Experience

Patients generally provided positive feedback about their experiences at the hospital. The patients we spoke with were complimentary about the care provided and about their interactions with staff. All patients who completed a HIW questionnaire rated the care and service provided by the hospital as either 'very good' or 'good'.

Health promotion, protection and improvement
Patients received physical assessments upon their admission and had access to a weekly health clinic on-site. We were told that patients are referred to appropriate screening services and other primary care health professionals when required. However, in one care and treatment plan we reviewed, it was recorded that a patient required dental provision due to tooth decay. We could not see evidence that arrangements had subsequently been put in place by the service for the patient to visit a dentist.

The service must ensure that patients are provided with access to a dentist and other health services when required and that appointments are clearly documented within patient records.

Patients on each ward had access to outdoor spaces, and all patients who completed a questionnaire confirmed that they are able to go outside for exercise and wellbeing purposes. Health promotion information was on display throughout the wards to encourage patients to take responsibility for their own health and wellbeing.

A weekly timetable of tailored therapeutic activities was available for patients to access. This included activities both on-site and within the local community. Patients also had access to a small gym and games room at the hospital. However, it was disappointing to find that the Social Hub was no longer in operation. During our previous visits, the hub included facilities such as a café and shop and was being run by some of the patients themselves. One staff member commented in the questionnaires:

> *"More could be done to help the patients to be more engaged and active. Since the hub has stopped doing things there is little going on for the patients especially on evenings and weekends."*

The service should evaluate the feasibility of reinstating the Social Hub to provide an opportunity for patients to engage and relax with each other when appropriate, and to help patients develop and gain employment skills.

Dignity and respect
Throughout the inspection we observed staff on all wards treating patients with dignity and respect. We saw patients on Chepstow being supported with personal care needs in a dignified and sensitive way by staff. All patients who completed a questionnaire said that staff treated them with dignity and respect, are always polite and provide care and treatment when needed.

Each patient had their own bedroom which they were able to personalise with pictures and posters and store possessions. During the inspection we saw examples of staff respecting the privacy of patients by knocking their door before entering. Patients could lock their rooms, but staff could override the locks if required. Bedrooms were not en-suite however there were sufficient communal toilets and showers available on each ward.

Suitable visiting arrangements were in place for patients to meet visitors at the hospital.

Patient information and consent
A good range of information was on display in the family room. Information on third sector support services for patients was displayed throughout the hospital. Some of the posters appeared faded, and the service may wish to refresh the information on display. Each patient is provided with an information booklet upon admission. We were provided with a copy and saw it was comprehensive and of good quality. A wide range of other information leaflets were available for patients which included information on the Mental Health Act and how patients could access tribunals to appeal their detention.

'Patient status at a glance' boards were located in the nursing offices on each ward. These were areas which patients could not access and therefore helped protect patient confidentiality.

Communicating effectively
Staff communicated appropriately with patients throughout the inspection. Patients who completed a questionnaire felt that staff listened to them. Patients were each allocated their own key nurse, and the majority of patients told us that they were able to speak to their key nurse every two to three days.

Each ward held weekly community meetings which provided an opportunity for patients to raise any issues with staff. We attended one of these meetings during

the inspection and noted that it was well attended by patients and staff, and we heard useful discussions taking place.

We noted that patient information was predominantly only available in English. We were told that language needs are discussed with patients prior to admission, and arrangements would be made for translation services if required.

Care planning and provision
During the inspection we reviewed the care and treatment plans of four patients. We found that care plans were person centred, with each patient having their own programme of care that reflected their individual needs and risks. Patients who completed a questionnaire said that they were given the opportunity to discuss any aspect of their care and treatment plan and felt quite involved in the process. The majority of staff members who completed a questionnaire also felt that patients are kept informed and are involved in decisions about their care.

More findings on the care plans can be found within the Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision section of this report.

Equality, diversity and human rights
We saw that the service had an up-to-date equality and diversity policy in place to help ensure that rights of each patient were respected. It was positive to note that a process for supporting transgender patients had been produced for staff. We observed staff referring to patients using their preferred pronouns throughout the inspection.

We saw evidence that 94 per cent of staff had completed mandatory Equality and Diversity training as part of their role.

An information leaflet was available for patients that described and informed patients about their rights while at the hospital. The patients who completed a questionnaire confirmed that they had been given information about their legal rights. The Mental Health Act documentation we reviewed during the inspection showed that all patients at the hospital had been legally detained. Further information on our findings is detailed in the Mental Health Act Monitoring section of this report.

We were told that all patients have access to a mental health advocate who visits the hospital once a week to provide information and support to patients with any issues they may have regarding their care.

Citizen engagement and feedback
Patients could engage and provide informal feedback to staff at the weekly community meetings and during their individual sessions with their key nurse. A complaints box was located in the reception area and the patients we spoke with told us that they knew how to make a complaint should they need to do so.

We were told that patients are asked to complete outcome measure questionnaires every quarter. We saw that the assistant psychologists at the hospital had produced reports based on the results of the questionnaires. The reports contained recommendations to help improve patient experience and their wellbeing which we noted as good practice.

Delivery of Safe and Effective Care

Safe Care

Managing risk and health and safety
Overall, the service had suitable processes in place to manage and review risks to help maintain the health and safety of patients, staff and visitors at the hospital. The hospital entrance was accessible to everyone and was secured at all times throughout the inspection to prevent unauthorised access.

Nurse call points were located within patient bedrooms so that patients could summon assistance if required. Staff wore personal alarms which they could activate in the event of an emergency. There were up-to-date ligature point risk assessments in place and a number of ligature cutters located throughout the hospital for use in the event of a self-harm emergency. Suitable fire safety measures and precautions were being taken to protect patients and staff in the event of a fire.

The environment of each ward was accessible for patients with mobility difficulties. The environment appeared to be safe, however we did note some damaged chairs in one of the dining rooms.

The service must ensure all damaged dining chairs are replaced or repaired as appropriate.

We were told that only reception staff had access to the maintenance system to raise issues with the environment. This meant that ward staff could not immediately report an issue themselves. The ward staff we spoke with did not know whether maintenance requests to repair broken upholstery and replace sofas had been raised.

The service must review access to the maintenance system to ensure it is effective at raising and repairing issues in a timely manner, and that staff are kept informed of requests made.

Infection prevention and control (IPC) and decontamination
During the inspection we considered the cleanliness of the patient and clinical areas at the hospital. We identified poor standards of cleanliness throughout all wards and the condition of the premises we observed was not reflective of a modern inpatient mental health service. For example:

- We saw some leather sofas on Chepstow and Cardigan had their material worn away in places which meant they could not be effectively cleaned
- There were cobwebs on the side wall next to the storage cupboard in the clinic room on Cardigan
- The dining rooms on Cardigan and Caernarfon had stained worktops and what appeared to be mould or dirt behind the sealant of the worktops and floors
- The soap dispensers in the dining room on Caernarfon were empty which meant patients could not wash their hands effectively before eating
- The foot pedals on the majority of bins throughout the hospital were dirty
- All clinic room floors were cluttered with storage and empty spare sharps bins
- The sharps bins in use were also being stored on the floor in all clinic rooms
- The communal bathroom on Cardigan had a broken seal which was mouldy, and what appeared to be dirt or mould around the overflow
- The skirting boards throughout the hospital did not always have sealant which meant there were gaps that could not be effectively cleaned
- The gap between the wall and door to the communal lounge on Caernarfon was dirty
- The quiet room floor on Cardigan had areas that had worn away
- One of the clinic room walls had plaster missing where the medication hatch had been hitting it when being opened fully
- Dust and debris was visible on the majority of skirting board corners throughout the hospital
- The wooden shelving in all clinic rooms were stained and in need of repainting.

We were provided with recent audit reports and environmental checklists undertaken throughout the hospital. We were concerned about the accuracy and quality of data being recorded because they had not identified the same issues and therefore did not provide a true reflection of the environment observed during the inspection. For example:

- The general manager checklists that we were provided with were not dated and did not record which unit was being assessed
- The general manager checklist indicated that all sharps bins were being stored off the floor in line with hospital policy
- The managers walkaround checklists indicated that all the floors were clean and that all furniture was in good condition
- The Iris Care Group Quality Monitoring Tool completed on 11/09/23 and 02/10/23 did not identify any issues in relation to the cleanliness of the environment.

Furthermore, cleaning schedules we were provided with during the inspection had numerous gaps, which indicated that the required cleaning tasks were not always being undertaken.

As a result of these findings, we were not assured that:

- The premises provided a clean, safe and secure environment in line with current legislation and best practice
- The premises were being kept in a good state of repair internally
- Patients and staff were being protected from healthcare associated infection through the maintenance of appropriate standards of cleanliness and hygiene
- The service was identifying, assessing and managing risks relating to the health, welfare and safety of patients and others.

Our concerns were dealt with under our non-compliance process. This meant that we wrote to the service immediately following the inspection issuing a non-compliance notice requiring that urgent remedial actions were taken. Details of the actions taken by the service are provided in Appendix B.

We were told that there was housekeeping provision seven days a week. However, there were only four cleaners, who each worked five days a week. This meant that on some days each cleaner was responsible for cleaning two wards. We were also told that it was the responsibility of the clinical nurses to clean their clinic room floors. One staff member commented in the questionnaires:

> *"Cleaners need to be more thorough as this gives support workers more time to concentrate on the patients. We need patients to live in a clean environment, but a lot of cleaning is left to support workers making less activities and time for patients."*

The service must review the housekeeping provision to ensure that it is sufficient to ensure effective cleaning of all areas of the hospital. Furthermore, the service must review the cleaning roles and responsibilities to ensure that there is not a negative impact on the ability of staff to spend time with patients.

We saw that 92 per cent of staff had completed their mandatory IPC training. We were told that the hospital did not have an appointed IPC lead. The hospital received support from the corporate IPC team at Iris Care Group. In light of the issues we identified during the inspection, the service may wish to consider appointing an internal IPC lead at the hospital to help drive improvement in this area.

Nutrition
We saw evidence that the dietary needs of patients had been assessed on admission and that specific dietary requirements had been identified and acted upon where necessary. All patients received ongoing weight management checks at the health clinic during their stay. Patients were able to receive weekly support from a dietician and Speech and Language Therapy (SALT) services.

There were suitable facilities available for patients to have hot and cold drinks and we saw patients accessing these throughout the inspection. Staffed kitchens are located on site to provide patients on each ward with a variety of meals throughout the day. The food appeared appetising, and we noted that healthier options were available. Patients who completed a questionnaire agreed that the food at the hospital was good and met their dietary requirements.

Kitchen staff attended the weekly community meetings to enable patients to raise any issues and to have input in the menus and suggest changes, which we noted as good practice.

Medicines management
Relevant policies, such as medicines management and rapid tranquillisation, were available and staff told us that they knew how to access them.

It was previously mentioned in the report that we found each clinic room at the hospital to be generally untidy, disorganised and in some cases unclean. The clinic rooms were small with limited storage options, which appeared to be contributing factors. We received assurance from the service following the inspection that the clinic rooms have been cleaned, and that storage has since been reviewed to reduce clutter and unnecessary items.

We saw that clinical nurses wore a red tabard when administering medication to patients which showed patients and other staff that the nurse should not be distracted. We noted that some patients were having their medication administered through a hatch in the clinic room door. This meant that patients were receiving their medication in a corridor where potentially other patients could be present. It also made it more difficult for clinical staff to check that patients were taking their medication.

The service must review the way medication is administered to fully protect the safety, privacy and confidentiality of patients.

We saw that all cupboards containing medication were locked, and all medication trolleys were locked and secured to the wall during the inspection. However, we found the medication fridge to be unlocked on occasions on Chepstow and

Caernarfon. We also found a small number of gaps in the daily temperature checking sheet of the medication fridges on Chepstow and Caernarfon.

The service must remind clinical staff to lock medication fridges when not in use and to complete the daily medication fridge temperature checklist to ensure that medication is being stored at the manufacturer's advised temperature.

Appropriate arrangements were in place for the storage and safe use of controlled drugs and drugs liable to misuse. Drugs were stored securely and the records we viewed evidenced that stock was accounted for when administered and that stock checks were being undertaken.

There was good support available from an external pharmacist who visited the hospital weekly to undertake audits and provide general support to doctors and clinical nurses.

HIW had been notified by the service of medication errors that had occurred at the hospital in the months prior to the inspection. We looked at the medication arrangements in place during the inspection and it was positive to note that the service had recently implemented an electronic Medication Administration Record (MAR charts) system. The system helped to ensure MAR charts were completed appropriately and we saw that MAR charts were being maintained to a good standard. We were told that there had not been a medication error since the implementation of the new system which was positive.

We saw that consent to treatment certificates were available on the electronic Medication Administration Record system. However, on one occasion we noted that a patient had been prescribed medication that had not been stated on the consent to treatment certificate in place to authorise the treatment.

The service must ensure that consent to treatment certificates always state the correct type and dosage of medication that has been prescribed to patients.

Safeguarding children and safeguarding vulnerable adults
We found processes in place to help ensure that staff at the hospital safeguarded patients appropriately. A designated safeguarding lead had been appointed who had overall responsibility for ensuring patients were safeguarded appropriately while at the hospital. A register of safeguarding incidents was being maintained and we saw that incidents had been appropriately referred to external safeguarding agencies.

There were suitable procedures in place for senior staff to review safeguarding incidents to identify themes or trends and any lessons learned. Compliance among staff at the hospital with safeguarding training was high at 92 per cent.

A designated room was available for families and children to visit patients at the hospital where appropriate.

Medical devices, equipment and diagnostic systems
We saw evidence of weekly checks being undertaken on resuscitation and emergency equipment held on each ward. Staff had documented when these had occurred to ensure that the equipment was present and in date.

During the inspection we noted that the service had some, but not all, of the emergency drugs recommended by the Resuscitation Council UK to be available at an inpatient mental health setting in case of a medical emergency. We were told that this had been identified by the service prior to the inspection and that they were awaiting delivery of full emergency drug bags from the external pharmacist. We received assurance shortly after the inspection that the emergency drug bags had been delivered and were subsequently available on each ward.

Safe and clinically effective care
The hospital had policies in place to help protect the safety and wellbeing of patients and staff. The majority of staff who completed a questionnaire felt that patient care is the organisation's top priority and that they are content with the efforts of the organisation to keep them and patients safe. Staff also agreed that they were satisfied with the quality of care and support they give to patients.

The patients we spoke with during the inspection told us that they felt safe at the hospital. However, some of the patients who completed a questionnaire said that they did not feel safe from other patients while at the hospital.

The service must engage with patients to identify ways of making all patients feel safe during their stay at the hospital.

Principles of positive behavioural support were being used as a primary method of de-escalation to manage challenging behaviour. Each patient had a ‘My safety and support’ plan in place which we noted were completed to a good standard. They described individual triggers and outlined the strategies to use to de-escalate challenging behaviour without physical intervention.

We were told that staff would observe patients more frequently if patients continued to present with increased risks. We saw that records of observations being undertaken on patients were being completed appropriately by nursing staff.

We saw evidence that 88 per cent of staff had completed Physical Intervention training. We saw that any use of restraint was documented in patient records and recorded on the corporate electronic system. This included details such as duration of the intervention and type of restraint used. We were told that debriefs take place with staff following incidents to check on their welfare, reflect, and identify any areas for improvement.

A safety huddle was being held every morning for staff to update the MDT and senior management on any events that had taken place the day before. We attended one of these meetings during the inspection and heard effective discussions taking place in relation to concerns, issues or incidents regarding each patient.

During the inspection we looked at the arrangements in place to safely manage a medical emergency, particularly in relation to resuscitation following a patient collapse. We were provided with a list of 33 staff members of varying roles who would be expected to lead in the event of resuscitation needing to be undertaken on a patient. Upon reviewing the list, we found that:

- 52 per cent of the staff members had not undertaken First Aid at Work (FAW) training
- 15 per cent of the staff members were out of compliance with their previous FAW training having expired
- 91 per cent of the staff members had not undertaken Immediate Life Support (ILS) training.

Furthermore, during discussions with two of the 33 staff members, they informed us that they would not know how to use the emergency equipment available at the hospital to safely manage the airways of a patient during resuscitation. This meant we could not be assured that staff had received appropriate training in relation to resuscitation to ensure the welfare and safety of the patient.

Our concerns formed part of the non-compliance notice issued to the service immediately following the inspection. Details of the actions taken by the service are provided in Appendix B.

Records management
Patient records were being maintained on paper files and electronically. We saw that paper records were being stored securely. The electronic records were password protected to prevent unauthorised access and breaches in confidentiality.

We noted that alongside paper records, the service was using an electronic patient record system, as well as a shared network drive. The service was in the process of implementing a new electronic patient record system to help streamline patient information.

Mental Health Act Monitoring
We reviewed the Mental Health Act (MHA) statutory detention documentation of four patients currently residing at the hospital. All records verified that the patients were being legally detained. Clear reasons were being documented to evidence why detention under the Act was the most appropriate way of providing care for patients.

We saw that information was being provided to patients following their admission about their detention and their legal rights. Good arrangements were in place to document Section 17 leave appropriately. We saw that leave was being suitably risk assessed and that the forms determined the conditions and outcomes of the leave for each patient. There was evidence that patients had been provided with, or offered, a copy of their leave form.

We looked at the arrangements in place at the hospital to assess the capacity of patients to make decisions for themselves. We saw evidence that consent to treatments certificates were being completed. However, in all four patient records we reviewed we could not see any documented evidence of the formal capacity assessments that had been undertaken to determine that patients were able to make decisions for themselves.

The service must provide assurance to HIW that patients have received a capacity assessment as required and ensure that all capacity assessments are documented and stored within patient records to be accessible by staff.

Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision
The four care and treatment plans we reviewed were generally being maintained in line with the Mental Health (Wales) Measure 2010. They were person centred and reflected the needs and risks of the individual patients. They set out a range of interventions for patients, including therapeutic and social activities, and listed who was responsible for their delivery.

We saw evidence that the social, cultural and spiritual needs of patients had been considered and that the care and treatment plans identified the strengths of the individuals to help focus on their recovery and independence.

We saw that monthly ward rounds were being held by the MDT to discuss the progress and care of each patient. It was positive that patients were invited to attend to be involved in the discussion.

However, we noted that:

- It was not always easy to locate the latest version of the care and treatment plans for each patient. Some care and treatment plans appeared out of date in the paper files, but staff were able to provide updated versions from the shared drive
- Some risk assessments had not been updated when required
- Some care plans had not been updated since admission and therefore did not include up to date interventions or patient goals. For example, one patient had been referred for a medium secure gatekeeping assessment, however the 'Accommodation' Care Plan referred to the patient as being 'appropriately placed', with care plan review notes limited to 'still resides on Cardigan'
- It appeared that senior support workers were reviewing the care and treatment plans rather than the primary nurse
- The review notes we saw contained little detail and appeared generic with similar entries each month. For example, 'Keeping Well' care plan review notes stated 'patient remains detained' with no further information around other points in the care plan. They did not indicate that a discussion had been had with the patients around their views or progress or future goals
- We did not always see evidence that the families and relatives of patients had been involved in their care and treatment planning (when appropriate, and if the patient wishes this to happen)
- One care and treatment plan we reviewed did not identify a care co-ordinator or primary nurse for the patient.

The service must ensure care and treatment plans are reviewed regularly and maintained in line with the Code of Practice to Parts 2 and 3 of the Mental Health (Wales) Measure 2010.

Quality of Management and Leadership

Staff Feedback

We invited staff to complete HIW questionnaires following the inspection to obtain their views on the service provided at the hospital. In total we received 25 completed questionnaires. The majority of staff members who completed a questionnaire said that they would recommend their mental health setting as a place to work and agreed that they would be happy with the standard of care provided for their friends or family. Other questionnaire results appear throughout the report.

We asked staff in the questionnaires what could be done to improve the service. Comments included the following:

> *"I believe the commitment from the staff team to support extremely complex patients is second to none. They constantly go over and above in ensuring that our patients' needs are met."*

> *"Improvement with certain members of the MDT working together. Some members of the MDT come across as not taking patients interests into consideration and believing that their role is more important than other members of the MDT."*

However, we also received comments in the questionnaires from staff members who did not wish for HIW to include their full comments in the report. Although the comments were only made by a small number of staff, the feedback was concerning, and indicated that there was a poor working environment at the hospital, with references made to a bullying culture, cliques, poor communication between clinical staff and the MDT members, intimidating senior management and decisions being made in the best interest of the service rather than clinical need or in the best interests of patients.

The service must engage further with staff to fully understand their views and provide assurance to HIW on what actions it will take to address the concerns raised.

Governance and accountability framework

We found established governance arrangements in place to provide oversight of clinical and operational issues. Audit activities and monitoring systems and processes were in place to ensure the hospital focussed on continuously maintaining standards. Agendas for clinical governance meetings showed a wide

range of standing items to help ensure that the hospital focussed on all aspects of the service.

Further oversight of the performance of the hospital is managed corporately through the Iris Care Group corporate teams. We saw evidence that the responsible individual had been visiting the setting to produce a written report on the standard of treatment and services being provided at the hospital.

Iris Care Group had recently taken over the hospital and we noted that some policies were in need of updating to reflect the processes of the new organisation rather than the previous owners. Senior staff assured us that a project was in place to review and update the library of policies and that the new policies would be shared with staff once ratified.

The majority of staff members who completed a questionnaire agreed that their line manager can be counted on to help me with a difficult task at work and provides clear feedback on their work. However, less staff members felt that their manager asks for their opinion before making decisions that affect their work.

Just over a quarter of staff members who completed a questionnaire disagreed that senior managers were visible, and just over a third of staff members disagreed that communication between senior management and staff is effective. However, the majority of staff members agreed that senior managers were committed to patient care.

Dealing with concerns and managing incidents
There was an established electronic system in place for recording, reviewing and monitoring incidents. Regular incident reports were produced and reviewed at the hospital level, and at a corporate level, to help identify trends and patterns of behaviour. Individual incidents were being discussed with members of the MDT and senior staff at the daily meetings and the monthly clinical governance committees.

The majority of staff members who completed a questionnaire told us that they would know how to report unsafe practice, and that their organisation encourages them to report errors, near misses or incidents. The majority of staff also said they would feel secure raising concerns about patient care or other issues at the hospital.

Workforce planning, training and organisational development
Staffing levels appeared to be appropriate to maintain patient safety within the wards at the time of our inspection. However, we were told that there are a number of current vacancies at the hospital including domestic and clinical staff. Regular agency staff who were familiar with working at the hospital and the

patient group have been used to cover any staffing shortfalls. The majority of staff members who completed a questionnaire agreed that they were able to meet their conflicting demands on their time at work. Less staff members agreed that there are enough staff for them to do their job properly. Some staff members provided the following comments in the questionnaires:

> *"Low staffing, low pay, high workload both on ward and within psychology."*
>
> *"Staff on the floor work very hard in a demanding environment which is not often addressed or mentioned."*

The service must continue to recruit more permanent staff to reduce the feeling among some staff that they do not have enough time to give patients the care they need.

We saw that suitable processes were in place for senior staff to monitor compliance with mandatory training. Staff members who completed a questionnaire told us that they have had appropriate training to undertake their role.

We were told that opportunities are available for staff to develop, including clinical supervision. Staff receive annual performance development reviews to discuss their performance and set annual objectives. However, senior staff were unable to provide confirmation on how many staff members had received their annual appraisal. More than a third of staff members who completed a questionnaire said that they had not had an appraisal, annual review or development review of their work within the last 12 months.

The service must ensure that staff members receive their annual performance development reviews and provide evidence to HIW on current compliance rates.

Workforce recruitment and employment practices

A recruitment policy was in place that set out the arrangements to ensure recruitment followed an open and fair process. Safety checks are undertaken prior to employment to help ensure staff are fit to work at the hospital. These include the provision of a satisfactory professional and character reference from a previous employer, evidence of professional qualifications and a Disclosure and Barring Service (DBS) check. Newly appointed permanent staff receive a period of induction where they are required to read company policies and complete mandatory training.

A whistleblowing policy was in place should staff wish to raise any concerns about issues at the hospital. Staff were able to speak to their immediate manager or contact a 'freedom to speak up guardian' in confidence.

The majority of staff members who completed a questionnaire felt that their job was not detrimental to their health. However, less staff members felt that their organisation takes positive action on health and wellbeing. Staff members confirmed that they were aware of the occupational health support available to them should they need it.

4. Next steps

Where we have identified improvements and immediate concerns during our inspection which require the service to take action, these are detailed in the following ways within the appendices of this report (where these apply):

- Appendix A: Includes a summary of any concerns regarding patient safety which were escalated and resolved during the inspection
- Appendix B: Includes any immediate concerns regarding patient safety where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking
- Appendix C: Includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

The improvement plans should:

- Clearly state how the findings identified will be addressed
- Ensure actions taken in response to the issues identified are specific, measurable, achievable, realistic and timed
- Include enough detail to provide HIW and the public with assurance that the findings identified will be sufficiently addressed
- Ensure required evidence against stated actions is provided to HIW within three months of the inspection.

As a result of the findings from this inspection the service should:

- Ensure that findings are not systemic across other areas within the wider organisation
- Provide HIW with updates where actions remain outstanding and/or in progress, to confirm when these have been addressed.

The improvement plan, once agreed, will be published on HIW's website.

Appendix A – Summary of concerns resolved during the inspection

The table below summaries the concerns identified and escalated during our inspection. Due to the impact/potential impact on patient care and treatment these concerns needed to be addressed straight away, during the inspection.

Immediate concerns Identified	Impact/potential impact on patient care and treatment	How HIW escalated the concern	How the concern was resolved
No immediate concerns were identified on this inspection.			

Appendix B - Immediate improvement plan

Service: Heatherwood Court

Date of inspection: 04, 05 and 06 December 2023

The table below includes any immediate non-compliance concerns about patient safety identified during the inspection where we require the service to complete an immediate improvement plan telling us about the urgent actions they are taking.

Improvement needed	Standard/ Regulation	Timescale	Service action
The service must ensure all areas of the hospital are thoroughly deep cleaned and must undertake maintenance work to ensure all areas of the hospital are in a good state of repair and appearance to adhere with best practice infection prevention and control (IPC) standards.	15(7) 15(8)(c) 26(2)(a) 26(2)(b)	Immediately and then ongoing	1. Maintenance teams have been in since Wednesday and they have replaced and cleaned all the silicone seals. Conversation to be had with Head of Capital Projects re an alternative material for the seals as silicone is not appropriate. 2. Any damaged furniture has been removed and replaced with new. 3. Cleaning product for the pineapple chairs has been ordered. If this doesn't clean the chair sufficiently, they will all be recovered. 4. Industrial cleaning team has been booked and awaiting a date for clean. 5. Painters are still in the service ensuring all surfaces are clean and well presented. 6. Any damaged walls are being repaired or reinforced as appropriate (this will continue monthly).

			7. Cleaning audits have been reviewed whilst HIW on site and these will be reviewed following a 4-week period for efficiency using the Governance agenda. 8. All bins have been replaced and now on the cleaning schedules. 9. Clinic room storage has been reviewed to reduce clutter and unnecessary items being stored in these rooms. 10. Flooring for the one clinic room has been ordered. 11. Bathroom stains were addressed on the day and added to the audit schedule for future review. 12. Excess sharps bins have been removed and bins in use are stored appropriately and off the floor. 13. Quality Team audit is being revised to ensure it captures all aspects of cleanliness and infection control.
The service must ensure that IPC audits and reviews are accurately completed and are effective in identifying improvements that are required in relation to cleanliness and good hygiene.	19(1)(b)	Immediately and then ongoing	1. In the new Integrated Infection Control Policy there is a new audit template, which will be completed by HWC and will identify the issues in relation to cleanliness and will be adopted moving forward. 2. Feedback has also been provided to the Head of Quality to review on the quarterly audits undertaken in each hospital.
The service must provide assurance on how it will ensure that a sufficient amount of appropriately trained members of staff are	15(1)(b)	Immediately	1. Cardiac arrest drills being completed monthly with all staff to ensure competence and confident with CPR and choke management drills (in line with resuscitation council)

available on-site at all times to undertake resuscitation in the event of an emergency to ensure the welfare and safety of the patient.			2. In the interim period of ILS training being rolled out all nurses will receive training in: • AED • Airway management – insertion of airways • CPR Training roll out will be completed by February 2024.
The service must ensure all staff members expected to lead in the event of resuscitation complete the required level of training as a matter of urgency.	20(2)(a)	Immediately and then ongoing	1. In the interim period of ILS training being rolled out all nurses will receive training in: • AED • Airway management • CPR 2. ILS training to replace the FAW training roll out in 2024.

Appendix C - Improvement plan

Service: Heatherwood Court

Date of inspection: 04, 05 and 06 December 2023

The table below includes any other improvements identified during the inspection where we require the service to complete an improvement plan telling us about the actions they are taking to address these areas.

Improvement needed	Standard/ Regulation	Service action	Responsible officer	Timescale
The service must ensure that patients are provided with access to a dentist and other health services when required and that appointments are clearly documented within patient records.	Health promotion, protection and improvement	A full audit will be undertaken for last contact with dental and other health service for all patients within HWC and ensure they have been seen for their last routine check-up and ensure this has been documented in their Care Partner notes. Anyone who has not had an appointment continues to await NHS allocation via the health board and for dental complications would access the emergency dentist triage (Dewi Sant). HWC has been raising concerns about the access to primary provisions for patients within the hospital, this highlighting this during the inspection in December 2023	Olivia Ferrari	10/04/24

		as well and this being escalated by the Clinical Director of ICG in a letter to HIW that was sent on the 4th of January 2024.		
The service should evaluate the feasibility of reinstating the Social Hub to provide an opportunity for patients to engage and relax with each other when appropriate, and to help patients develop and gain employment skills.	Health promotion, protection and improvement	An Activities Coordinator has been appointed in January 2024, who is working with all disciplines to encourage sessions and activities to be facilitated more in the hub, and to look at additional social events and opportunities to expand the function of the hub to provide further development opportunities for the patients. Draft timetable attached; however, this is an ongoing action which is being reviewed in monthly governance for oversight.	Olivia Ferrari	April 2024
The service must ensure all damaged dining chairs are replaced or repaired as appropriate.	Managing risk and health and safety	Our Infection Control Audit, Quality Audit and internal Environmental check audits have all been improved to ensure the furniture is reviewed and any ripped / damaged furniture is included with the instructions to remove immediately and replace. This is then reviewed weekly by	Lydia Bevan / Olivia Ferrari	March 2024

		General Manager and Hospital Director has oversight.		
The service must review access to the maintenance system to ensure it is effective at raising and repairing issues in a timely manner, and that staff are kept informed of requests made.	Managing risk and health and safety	This was actioned during the inspection and fed back to the inspection team on the 2nd day of the inspection. Maintenance feedback is discussed within Local Governance meetings, patient voice and staff meetings on a monthly basis. Monthly report submitted for Governance will also be displayed in the unit offices, to ensure as many staff as possible are kept updated of actions completed and any outstanding tasks with updates. The monthly reports will also be circulated to each unit so everyone also has access to an electronic copy.	Lydia Bevan	March 2024
The service must review the housekeeping provision to ensure that it is sufficient to ensure effective cleaning of all areas of the hospital. Furthermore, the service must review the cleaning roles and responsibilities	Infection prevention and control (IPC) and decontamination	In relation to the housekeeping team, the cleaning rosters were reviewed during the inspection and a deep cleaning company has been engaged.	Lydia Bevan	March 2024

to ensure that there is not a negative impact on the ability of staff to spend time with patients.		We are in the process of reviewing the housekeeping facility and will continue with deep cleaning on a regular basis until an internal solution is reached. Staff cleaning will be reviewed, and staff feedback will be sought in relation to their feelings of cleaning impacting on their ability to spend time with patients to establish what changes need to be made. Notices have been placed within all clinic rooms reminding nurses of individual responsibilities to leave the area how it has been found as a nurse has the responsibility to ensure medication is being administered within a clean and orderly environment – this does not include cleaning of clinic rooms floors, which is clearly documented and now auditing in the housekeeping responsibilities.		
The service must review the way medication is administered to fully	Medicines management	Following the feedback from HIW, we will engage with the patients in relation to how they would like their medication	Olivia Ferrari	May 20024

protect the safety, privacy and confidentiality of patients.		dispensed and review the environment and medication protocol for improved dispensing.		
The service must remind clinical staff to lock medication fridges when not in use and to complete the daily medication fridge temperature checklist to ensure that medication is being stored at the manufacturer's advised temperature.	Medicines management	Additional level of checks is now in situ in relation to the daily fridge recording and spot checks throughout the day by the unit managers are taking place to ensure the fridges are locked. This will be discussed again in supervisions and nurse meetings.	Olivia Ferrari	April 2024
The service must ensure that consent to treatment certificates always state the correct type and dosage of medication that has been prescribed to patients.	Medicines management	This has been addressed with the medical staff and is now present on the Consent to Treatment certificates.	Olivia Ferrari	March 2024
The service must engage with patients to identify ways of making all patients feel safe during their stay at the hospital.	Safe and clinically effective care	HWC currently facilitates weekly patient meetings – End of Week patient meeting; staying safe meeting; connections and moving forward meeting. There is also weekly Primary Team sessions on a one-to-one basis with a member of the individuals Primary Team, we have quarterly REQOL and ESSEN	Olivia Ferrari	April 2024

		questionnaires with MDT review and actioning from the outcomes which specifically address feelings of safety, patients have full access to the nursing and psychology team to have talk time with if they do not feel safe daily. However, following inspection feedback the Management team will arrange focus groups with the patients to find out how the service could further improve on this standard and ensure the above processes meet the needs of the patients..		
The service must provide assurance to HIW that patients have received a capacity assessment as required and ensure that all capacity assessments are documented and stored within patient records to be accessible by staff.	Mental Health Act Monitoring	Discussion has taken place within SMT for dissemination to all teams that any capacity discussions / meetings that take place must be formally documented on the company format and stored within the patient notes for ease of reference and access.	Olivia Ferrari / Sarah House / Andrew Hider	March 2024
The service must ensure care and treatment plans are reviewed regularly and maintained in line with the Code of Practice to Parts 2 and 3	Monitoring the Mental Health (Wales) Measure 2010: Care planning and provision	Content requirements to be discussed within relevant staff meetings and Quality of Notes audit to reflect the content of these reviews. Care Plans will be reviewed as part of the Primary	Olivia Ferrari	April 2024

of the Mental Health (Wales) Measure 2010.		Teams and overseen by the Primary Nurse/Unit Manager for counter signatures.		
The service must engage further with staff to fully understand their views and provide assurance to HIW on what actions it will take to address the concerns raised.	Quality of Management and Leadership	The below avenues are available to staff currently in relation to input into the service and feedback on any improvements or changes to practice they feel necessary: • Staff forums are held every 3 months for HWC for all teams and this forum is overseen and chaired by OD SH and HD OF, with Humana Resources dept in attendance. All minutes of the meeting, alongside the actions noted are circulated to staff with updates of progress provided. • Multiple staff meetings are held each month to ensure that 'staffs voice' are heard and to ensure evidence of how the team's feedback is listened too and actioned. All meeting minutes are circulated to the teams, this evidencing areas of discussion and actions taken.	Olivia Ferrari	April 2024

		• Team meeting and supervision templates follow a 'you said we did' theme, this focusing on 'Stop, Start, Keep'. • Questionnaires are circulated in line with culture from head office to look at 360 feedbacks to hospital management – This in line with learning initiatives for the service. • Wellbeing officer posters are placed throughout HWC, with contact information and signposting for support. This post is promoted throughout the hospital as a support measure for staff. • Whistle blowing policy has been circulated in team meetings and supervisions. However, following the inspection feedback focus groups will be facilitated to discuss with staff some areas raised in the report how staff would like to be engaged with and how we can improve the current practices to best meet their		

		needs. The results of these focus groups will be feedback via governance and produced in a 'you said, we did' format to ensure staff have feedback in relation to areas raised.		
The service must continue to recruit more permanent staff to reduce the feeling among some staff that they do not have enough time to give patients the care they need.	Workforce planning, training and organisational development	We have a full occupancy of support staff and currently 8 vacancies for nursing staff due to occupancy increases. We have had a very positive recruitment campaign over the last 12 months and our attrition is currently at 32% which is a big decrease from 12 months ago when it sat around 50%. There has been a focus on inductions, supervisions, staff forums and training to ensure staff feel valued and are involved in the service. However, following the feedback from the inspection report we will engage with staff through the staff forums and discuss with staff what actions they would like to see implemented to improve their quality time with the patients.	Olivia Ferrari	April 2024
The service must ensure that staff members receive their annual	Workforce planning, training and	All annual appraisals are 12 monthly and are due to for completion in line with the	Olivia Ferrari	May 2024

performance development reviews and provide evidence to HIW on current compliance rates.	organisational development	financial year. All appraisals should be fully completed by May 2024 and annually thereafter.		

The following section must be completed by a representative of the service who has overall responsibility and accountability for ensuring the improvement plan is actioned.

Service representative

Name (print): **Olivia Ferrari**

Job role: **Hospital Director**

Date: **15 March 2024**